COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

SARA REDDING WILSON
DIRECTOR

James Monroe Building
101 N. 14th Street
Richmond, Virginia 23219

To: State Retiree Health Benefits Program Participants Eligible for Medicare

From: Mary P. Habel, Director
State and Local Health Benefits Programs

Date: November 18, 2004

Re: --Medicare-Coordinating Plan Monthly Premium Rates Effective January 1, 2005
--Changes in Administration of Prescription Drug Benefit for 2005
--Retiree Group Updates

IMPORTANT INFORMATION: Please be sure to read these materials carefully to ensure that you understand premium and administrative changes that will take place in 2005.

Recipients of this Package: Retiree group participants receiving this package include Medicare-eligible Retirees, Survivors, Long Term Disability Participants and some eligible dependents who have separate, individual plans based on their Medicare eligibility.

Premium Rates for 2005: Monthly premium rates for Medicare-coordinating plan participants are listed below and will be effective January 1, 2005. Participants who pay their premium through deduction from their VRS retirement annuity will see the first deduction on their February 1 retirement payment. Participants who pay by direct bill will be billed for their new January premium in December.

Plan*	Current (2004) Single Premium	Your New 2005 Premium
Advantage 65	$244	**$293**
Advantage 65 + Dental/Vision	$271	**$320**
Medicare Complementary (Option I)	$216	**$259**
Medicare Supplemental (Option II)	$302	**$317**
Option II + Dental/Vision	$329	**$344**

*All State Retiree Health Benefits Program Medicare-coordinating plan medical, dental and vision benefits are administered by Anthem Blue Cross and Blue Shield. **See page two for more information about administration of your prescription drug benefit.**

Premium increases for 2005 were the result of continuing and substantial increases in claims expense. Even though Medicare is the primary payer of claims for medical expenses under these plans, increased utilization of medical services still had an impact on premium levels. However, once again, the cost of prescription drugs, especially in the Advantage 65 and Option I plans, was the primary driver of the premium increases. Under those plans, the prescription drug benefit represents approximately 63% of the total premium expense. Since there is currently no federal Medicare prescription drug benefit (other than discount cards), the program suffered the full impact of increases in prescription drug costs.

No Copayment, Coinsurance or Benefit Changes: All copayment/coinsurance levels and benefits will remain unchanged for 2005. However, while your plan benefit will not change, the Medicare Part B annual deductible will go up from $100 to $110 in 2005. Even though the plan provisions have not

changed, since Advantage 65 starts supplemental medical benefits after the annual Part B deductible is met, this does result in an additional $10 in annual deductible responsibility.

IMPORTANT—CHANGE IN PRESCRIPTION DRUG ADMINISTRATION:

Advantage 65 and Medicare Complementary (Option I) Participants--Effective January 1, 2005, prescription drug benefits under these plans will be administered directly by **Medco**. This means that **you will receive a separate Medco prescription drug card in addition to your medical card from Anthem Blue Cross and Blue Shield**. **Starting January 1, you will need to present your Medco card at your participating pharmacy in order to use your prescription drug benefit. If you present your Anthem ID card at the pharmacy after December 31, you will be denied prescription drug benefits.** In addition, Anthem will not be able to assist you with your prescription drug benefits for any services after December 31. You should receive your **Medco** card by **December 27** and your **Anthem** card by **December 28, 2004.**

If you have not received your Medco card by the above date, please contact Medco at 1-800-355-8279. All drug pre-authorizations and existing refill information will transfer to the Medco system. If you are using the Home Delivery Pharmacy, you may continue to use the same Medco Web site and toll-free number that you have used in 2004 to obtain pricing information and refills. However, you may go directly to the Medco Web site at www.medcohealth.com instead of accessing the Web site through Anthem. If you have not received your Anthem card by the above date, contact Anthem at 1-800-552-2682 or, if calling from the Richmond area, (804) 355-8506.

Medicare Supplemental (Option II) Participants—Medical benefits for this plan, including prescription drug benefits, will continue to be administered by Anthem Blue Cross and Blue Shield. **You will not receive a Medco card, but you will receive a new Anthem Card for use starting January 1, 2005.** If you do not receive your new card by December 28, 2004, please contact Anthem at 1-800-552-2682 or, if calling from the Richmond area, (804) 355-8506. You should present your new Anthem card at a participating pharmacy for any prescription drugs obtained after December 31, 2004. Prescription drug program information is located in the upper right corner of your Anthem ID card. You will also receive some program reminders along with your Anthem ID card. Be sure to refresh your memory about the **Automatic Drug Claim Filing Process** that is available to Option II participants.

No Change in Dental/Behavioral Health Administration for Medicare Retirees: Many of you may be aware that active employees and non-Medicare-eligible retirees or dependents now have separate administrators for their dental and behavioral health benefits. **Participants in Medicare-coordinating plans will see no change in the administration of these benefits.** Anthem Blue Cross and Blue Shield will continue to administer your Medicare-coordinating coverage for dental benefits (for those who have dental coverage). Anthem will also administer any secondary payments for behavioral health services based on primary payment by Medicare Part A or B.

UUUUNEW!--Automatic Bank Draft Available to Direct-Bill Participants: Retiree group participants who are billed directly by Anthem Blue Cross and Blue Shield for their monthly health plan premium will have a new payment option starting in January. If you are an Anthem direct-bill participant, you will find information and enrollment materials regarding the automatic bank draft option enclosed. By enrolling in this program, you will no longer have to write a monthly check for your premium payment. If you are paying your monthly premium directly, be sure to read the enclosed materials.

Making Allowable Plan Changes: If you wish to maintain your current plan, no action on your part is necessary. Your new monthly premium will automatically be deducted or billed in the usual manner. If, due to the change in premium, your retirement annuity no longer supports the deduction of your monthly premium, direct billing will automatically begin in December for your new January premium.

If you wish to make an allowable change in your coverage per plan provisions, your completed enrollment form must be received between December 1 and December 31, 2004, to ensure a January 1, 2005, effective date. Enrollment forms are available from your Benefits Administrator. If you are a VRS retiree, VSDP/LTD participant or survivor (or one of their dependents), you may contact the Virginia Retirement System at 1-888-827-3847 (or, if you are located in Richmond, 804-649-8059) to request a form. If you are an Optional Retirement Plan or Local Retiree (or one of their dependents), you should contact your last employing agency's Benefits Administrator. Forms are also available at the DHRM Web site at www.dhrm.virginia.gov/hbenefits/retiree.html. All enrollment forms requesting an allowable change must be signed by the Enrollee (retiree, survivor or LTD participant), not by a covered dependent. While some dependents receive packages addressed directly to them based on their separate plan coverage, only the Enrollee can authorize a plan or membership change. You may also make changes on line by using EmployeeDirect, which can be accessed at http://edirect.virginia.gov. Changes made on line must be completed by December 31, 2004, for a January 1, 2005, effective date. Requests for allowable changes received after December 31 will generally be effective the first of the month after receipt of the form (or receipt of the request through EmployeeDirect). Allowable changes (not associated with a qualifying mid-year event) include:

- **Removing dependents** (Dependents may not be added without the occurrence of a consistent qualifying mid-year event or, for non-Medicare Enrollees, at open enrollment, but Enrollees may drop dependent coverage at any time and it will be effective as explained above.)
- **Adding Dental/Vision to Advantage 65 or Option II** (This is allowed one time only—if you have previously discontinued Dental/Vision coverage under either plan, you may not add it again to either plan.)
- **Removing Dental/Vision from Advantage 65 or Option II** (Once this coverage is removed, you will not have another opportunity to add it in the future.)
- **Moving between Option I and Option II** (Current participants may move between those plans or to Advantage 65, but once Option I or II participants elect Advantage 65 coverage, they may not move back to Option I or II again in the future.)

If you elect one of the above changes, check *"Medicare Eligible Member Making Allowable Plan Change"* as the reason the form is being submitted (see Part A), and follow all enrollment form instructions carefully.

Requests for cancellation of coverage will be accepted in writing, **signed by the Enrollee**, without use of an enrollment form. The effective date of cancellation will be the first of the month after written notification is received. Once coverage has been terminated, there is not an opportunity to re-enroll.

ID Cards: As indicated on page two, **Advantage 65 and Medicare Complementary (Option I)** participants will receive two identification cards: one from Anthem for medical (and dental/vision benefits, if covered under your plan) and one from Medco for prescription drug benefits. Be sure to use your new cards for services starting January 1, 2005.

If you are enrolled in **Medicare Supplemental (Option II**), you will receive only one new ID card from Anthem Blue Cross and Blue Shield. This should be used for all services starting January 1, 2005. You will not receive a separate prescription drug ID card.

To ensure that participants have new cards for January 1, cards will be generated in December based on December's enrollment information. If you make a change in your coverage after generation of your new card(s), an updated card (or cards) will be received in approximately ten days from the date that your enrollment form is received.

Member Handbook Updates: A "Notification of Changes" to your Member Handbook(s) will be enclosed with your new Anthem ID card. These describe recent eligibility and administrative updates that affect your plan. Please review these changes carefully and keep them with your handbook(s). Complete new handbooks will not be issued at this time.

Medicare-Eligible Participants Under Age 65: When an Enrollee (retiree, survivor, LTD participant) or a covered dependent becomes eligible for Medicare prior to age 65, an enrollment form must be

submitted immediately to elect a Medicare-coordinating plan (or you may use EmployeeDirect). While this letter is being directed to participants already enrolled in Medicare-coordinating plans, we provide this information to ensure that other covered family members in non-Medicare plans are also moved to a plan that coordinates with Medicare immediately upon eligibility. It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so could result in significant coverage deficits.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B in order to get the full benefit of any state Medicare supplemental coverage since Medicare becomes the primary payer of claims. If it is determined that a retiree group participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in the Advantage 65 Plan immediately. (The addition of Dental/Vision coverage to Advantage 65, if elected, will generally be effective the first of the month after an enrollment form is received.) Starting in January 2005, primary payments made in error by the state program will be retracted back to either the Medicare claim filing limit, the date of Medicare eligibility or the date that retiree group coverage began. It will be the responsibility of the participant to arrange for submission of retracted claims to Medicare. If participants have declined their Medicare Part B coverage, it could result in a delay in Part B enrollment and a critical gap in coverage until Part B goes into effect. The state plan will not pay any claims that should have been paid by Medicare had the participant been properly enrolled in Medicare coverage.

Prompt Payment of Premiums: Plan participants are responsible for timely payment of their monthly premiums (either through annuity deduction or by direct payment to the carrier). Participants who pay directly to the carrier receive monthly bills which indicate when premium payments are due. **Starting in January 2005, retiree group participants who fail to pay their premium by the due date noted on their monthly invoice will have their claims put on hold (including prescription drugs) until their premiums are paid.** Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Once an Enrollee and his/her dependent(s) have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except in extreme circumstances and at the discretion of the Department of Human Resource Management. Direct-bill participants should consider enrolling in the new automatic bank draft option (see page two) to ensure prompt premium payments.

Participants are responsible for understanding their premium obligation and for notifying the program within 31 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee to advise the program of membership reductions may result in loss of the overpaid premium amount.

Resources for Retiree Group Enrollees: In addition to your Benefits Administrator and your plan's member handbook, there are many resources available at the Department of Human Resource Management's Web site to provide information to retiree group participants about their State Retiree Health Benefits Program coverage. Go to www.dhrm.virginia.gov, click on the *Compensation and Benefits* link, and select *Health Benefits for Retirees, LTD Participants and Survivors*. Retiree Fact Sheets, which are available at this link, contain subject-specific information directed to retiree group participants.

Address Changes: Was this package forwarded to you from an old address? If so, be sure to contact your Benefits Administrator immediately to make an address correction. Failure to update your address can result in your missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss because their address of record has not been corrected. The Department's only means of communicating important information to retiree group participants is through the mail. Please let us know when you move!

Newsletter: Please take a moment to read the enclosed *Open Forum* newsletter, which contains items of interest directed at retiree group participants.

Enclosures: *Open Forum* Newsletter
Automatic Bank Draft Materials (Anthem direct-bill participants only)